BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

| | | |
|---|---|---|
| In the Matter of the Accusation Against: | ) | |
| Lawrence Delano Tran, M.D. | ) | File No. 800-2016-026901 |
| Physician's and Surgeon's Certificate No. A 34193 | ) | |
| Respondent | ) | |

## DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 1, 2019.

IT IS SO ORDERED January 3, 2019.

MEDICAL BOARD OF CALIFORNIA

By: _____
Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6538
Facsimile: (213) 897-9395
*Attorneys for Complainant*

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>LAWRENCE DELANO TRAN, M.D.<br><br>2211 West Magnolia Boulevard, Suite 230<br>Burbank, California 91506<br><br>Physician's and Surgeon's Certificate A 34193,<br><br>Respondent. | Case No. 800-2016-026901<br><br>OAH No. 2018070154<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Respondent Lawrence Delano Tran, M.D. (Respondent) is represented in this proceeding by attorney Corey E. Krueger, of Ericksen Arbuthnot, 835 Wilshire Boulevard, Suite 500, Los Angeles, California 90017.

3. On July 30, 1979, the Board issued Physician's and Surgeon's Certificate No. A 34193 to Lawrence Delano Tran, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-026901, and will expire on November 30, 2018, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-026901 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 30, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2016-026901 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-026901. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2016-026901, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

**DISCIPLINARY ORDER**

**A. PUBLIC REPRIMAND**

**IT IS HEREBY ORDERED THAT** Physician's and Surgeon's Certificate No. A 34193 issued to Respondent Lawrence Delano Tran, M.D., shall be and is hereby publicly reprimanded

pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This public reprimand, which is issued in connection with Respondent's care and treatment of Patient A, as set forth in Accusation No. 800-2016-026901.

**IT IS FURTHER ORDERED THAT** Respondent comply with the following:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition. Respondent shall successfully complete the educational program(s) or course(s) and provide proof of attendance within one (1) year of the effective date of this Decision."

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of

this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. VIOLATION OF THIS AGREEMENT. Failure to comply with any term or condition of this Agreement is unprofessional conduct in violation of Business and Professions Code section 2234. If Respondent violates this agreement in any respect, the Board may file an Accusation and, after a hearing, discipline Respondent's Physician's and Surgeon's Certificate for unprofessional conduct in violation of Business and Professions Code section 2234.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Corey E. Krueger. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/19/2018

LAWRENCE DELANO TRAN, M.D.
*Respondent*

I have read and fully discussed with Respondent LAWRENCE DELANO TRAN, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11/19/2018

COREY E. KRUEGER
*Attorney for Respondent*

///

///

///

///

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 11/26/18

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
*Attorneys for Complainant*

LA2018600499
53146571.docx

# Exhibit A

**Accusation No. 800-2016-026901**

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6538
Facsimile: (213) 897-9395
*Attorneys for Complainant*



**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**LAWRENCE DELANO TRAN, M.D.**<br>**2211 W. Magnolia Blvd, Suite 230**<br>**Burbank, CA 91506**<br><br>**Physician's and Surgeon's Certificate No. A 34193,**<br><br>Respondent. | Case No. 800-2016-026901<br><br>**ACCUSATION** |

Complainant alleges:

**PARTIES**

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 30, 1979, the Medical Board issued Physician's and Surgeon's Certificate Number A 34193 to Lawrence Delano Tran, M.D. (Respondent). The Physician's and Surgeon's was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2018, unless renewed.

///

///

## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

7. Respondent Lawrence Delano Tran, M.D. is subject to disciplinary action under section 2234, subdivision (b) in that respondent committed gross negligence in the care and treatment of one patient. The circumstances are as follows:

8. Patient A[1], a female who was twenty-eight years old at the time, first presented to Respondent on April 24, 2013, complaining of swelling of both legs and a sunburn. She reported a family history of colon cancer. Respondent's History of Present Illness (HPI) did not list information about onset, duration, frequency, severity, location, relieving factors, exacerbating factors, description of symptoms the patient complained of.

9. Review of system, family history and social history were written down. The patient's exam was documented through a template. Respondent diagnosed patient with sunburn, noting that edema of lower extremities was due to sunburn of limbs. Respondent documented performance of a genitourinary exam, but during his interview with the Board investigators he claimed that this information was recorded on the patient's chart in error, as no such exam occurred. According to Respondent's assessment, he diagnosed patient A with "FAP." However,

[1] The patient's identity is known to Respondent. She is designated as "Patient A" in this document to protect her privacy.

during the Board interview he explained that this entry too, was an error and was intended to mean "FMF," or Familial Mediterranean Fever. Respondent never corrected this erroneous information in patient A's medical record.

10. Respondent also diagnosed patient A with photosensitivity and sunburn. The patient was given Medrol[2], offered a colonoscopy, and asked to follow-up in a week.

11. The patient returned to see Respondent almost a year later, on March 14, 2014, with a chief complaint of "stomach ... bothering her," according to the intake note made by Respondent's Medical Assistant. However, Respondent's separate electronic medical record documented that Patient A's chief complaint was "pap". Respondent did not obtain and/or did not document a History of Present Illness during this visit, but recorded in his assessment that the patient was suffering from endometriosis, without documenting or explaining in any adequate detail, the basis for this assessment.

12. According to the patient's medical record, Respondent performed a genitourinary exam, but documented inconsistent findings: the record states that the Patient's cervix was without stenosis, cervical motion tenderness, masses, lesions, or discharge, and at the same time that the patient's cervix was surgically absent. The exam of the patient's uterus was documented as normal, but also indicated the uterus was surgically absent. Respondent documented that the patient's adnexa was both normal and not palpable. During his interview with the Board investigators, Respondent explained that his documentation was not correct due to his unfamiliarity with use of a new electronic medical record (EMR) software. However, Respondent never made any correction or addendum to clarify these discrepancies in the patient's record.

13. Respondent assessed a diagnosis of endometriosis and irritable bowel syndrome, performed a PAP smear, obtained a blood culture and prescribed Donatal[3] PRN, and a pelvic

---

[2] This medication is a corticosteroid hormone. It decreases the patient's immune system's response to various diseases to reduce symptoms such as swelling, pain, and allergic reactions.

[3] Donnatal (belladonna alkaloids, phenobarbital) is a combination of an anticholinergic/antispasmodic drug and a barbiturate sedative used to treat abdominal pain, bloating and cramps in patients with irritable bowel syndrome.

ultrasound. Respondent's rationale behind diagnosis of endometriosis and irritable bowel syndrome were not clearly documented or logically outlined in the patient's record.

14. Patient A was next seen one week later, on March 21, 2014, complaining of 24 hours of epigastric pain. A note made by Respondent's medical assistant indicates that the patient's pain scale is "6" and "PT meds are not working out." Respondent's encounter note is devoid of pertinent details, including but not limited to: onset, duration, frequency, severity, location, relieving factors, exacerbating factors, and description of symptoms. On exam, the medical record states conflicting findings that the patient's stool is both negative and positive for occult blood. Respondent recorded an objective positive finding of microscopic hematuria. Respondent ordered STAT tests for abdominal, kidney/bladder, and pelvic ultrasounds, but his rationale for necessity of STAT tests is not documented. Vicodin, a Schedule III controlled substance is prescribed, but rationale for the necessity of an augmented level of pain control is not documented. Respondent did not consider and/or did not document a consideration of alternative, non-narcotic pain medications. Respondent never did correct or explain his conflicting findings in Patient A's medical record during this visit.

15. Patient A returned to visit Respondent on April 2, 2014. A note made by Respondent's medical assistant indicates that the patient is "here for a follow up on test results." Respondent documented in his encounter note that the reason for visits was "ultrasound reports." Respondent documented no history and a completely normal physical exam, but assessed a diagnoses of dyspepsia and indigestion. Respondent, however, did not document any history or exam findings to correlate to his assessments, and no reasoning to provide a rationale for his assessments. Respondent did not formulate and/or document a plan relating to these assessments. Instead, a plan for "smoking cessation urged" is noted, although there is no history or assessment made related to the patient's smoking.

16. Patient A returned to see Respondent on August 19, 2014. Respondent's Medical Assistant documented a chief complaint that Patient is "here for lab result and cough." Respondent's encounter note documented that the reason for the visit was "cough." History of Present Illness is lacking in pertinent details, including but not limited to: onset, duration,

frequency, severity, location, relieving factors, exacerbating factors, description of symptoms. Respondent documented a normal physical exam, with no respiratory symptoms, but documented that the physical exam was positive for Polyps. Respondent diagnosed Patient A with Endometriosis, Irritable Bowel Syndrome, Chronic Rhinitis, Rhinitis, and Acute Bronchitis. No rationale describing the reasoning for these assessments was documented. Respondent prescribed Z-pak (an antibiotic), Singulair, Phenergan, and Advair, though he did not document any indication for antibiotic use. Singulair and Advair were prescribed, even though there was no documentation of findings of wheezing or shortness of breath. Respondent was, or should have been aware that that non-sedating anti-histamines and intranasal steroids were options for allergic rhinitis, but did not consider and/or document his reasons to avoid these types of medicines.

17. Between August 30, 2014 and September 2, 2014, Patient A was hospitalized for acute right lower quadrant pain. She returned to see Respondent on September 9, 2014. A "chief complaint" recorded by Respondent's medical assistant indicates that the patient is "here for follow-up from hospital, R leg blood clot." In his encounter form, however, Respondent made no mention of the hospitalization. Instead, the reason for visit is listed as "Mediterranean fever suspect." History of Present Illness is lacking any pertinent details. A diagnosis of Familial Mediterranean Fever is made. There is no documentation of rationale describing the reasoning for this assessment. MEFV gene mutation testing was ordered, as well as a venous Doppler to rule out DVT (Deep Vein Thrombosis).

18. Patient A returned to see Respondent on November 21, 2014. The chief complaint was documented by Respondent's medical assistant as "patient has abdominal pain and nausea." Respondent's encounter note indicates that the reason for this visit was a 24 hour history of RLQ abdominal pain associated with nausea. The note is devoid of pertinent details, including but not limited to: onset, duration, frequency, severity, location, relieving factors, exacerbating factors, and description of symptoms. Normal abdominal exam is documented. An Ultrasound and STAT test of the patient's Complete Blood Count were ordered, but no other treatment or plan was considered and/or documented. The encounter note indicated that the patient was provided with educational materials, with no additional details.

19. Patient A returned to see Respondent on May 5, 2014. The chief reason for the visit, as documented by Respondent's Medical Assistant is "patient wants to stop smoking." Respondent took and/or documented no history and did not perform and/or document any details of physical examination. The patient was assessed with nicotine addiction, and prescribed Wellbutrin. Pap is ordered as well as QC/Chlamydia. There was no documentation regarding the rationale behind the pap and sexually transmitted disease (STD) testing, including in the record of history and physical exam (HPI).

20. On November 12, 2015, the patient returned for vaginal itching and STD check. HPI listed symptoms for the past 2-3 days, but otherwise it was devoid of pertinent details. No reason for STD check was documented.

21. The Patient was seen again on December 12, 2015 for "the same reason from last visit", with the same complaint of vaginal itching. Diagnosis of vaginal candidiasis[4] was recorded. The note is devoid of pertinent details, including but not limited to: onset, duration, frequency, severity, location, relieving factors, exacerbating factors, and description of symptoms. Diflucan[5] and metronidazole[6] were ordered. There are no exam findings consistent with vaginal candidiasis. No tests were ordered to support or confirm the diagnosis. There is no documentation regarding the rationale for a diagnosis of vaginal candidiasis. No rationale for the use of metronidazole was recorded in the patient's record. During his interview with the Medical Board, Respondent stated that it "would be reasonable to add metronidazole" along with the Diflucan. Respondent was unable to list contraindications/side effects for Flagyl during his interview with the Medical Board.

22. Patient A's next visit with Respondent was on February 11, 2016, for routine lab and STD check. Patients was noted to have 4 months of difficulty sleeping. Pertinent details are

[4] Yeast infection.
[5] Medicine used to treat fungal and yeast infections.
[6] An antibiotic, also known as Flagyl, that is used to treat a wide variety of bacterial infections.

missing in HPI. The physical exam was not performed and/or documented. A diagnosis of GERD[7] was made, although rationale for this diagnosis is unclear and undocumented.

23. Patient A was last seen by Respondent on August 25, 2016, for left shoulder pain, and another STD check, as well as a Vitamin B check. Respondent's patient encounter note is devoid of pertinent details, including but not limited to: onset, duration, frequency, severity, location, relieving factors, exacerbating factors, and description of symptoms. Physical exam is documented through template checklist. Thyroid-stimulating hormone (TSH) test and EKG are ordered but indications for these tests are unclear and undocumented.

24. Respondent departed from the standard of care by failing to obtain and document appropriate history and physical examination of Patient A as alleged in paragraphs 8 through 23. Respondent's consistent and repeated multiple failures to obtain and/or record the patient's history and physical examination, as alleged in paragraphs 8 through 23, represent an extreme departure from the standard of care.

25. Respondent departed from the standard of care by failing to communicate his rationale and information supportive of his assessments of Patient A as alleged in paragraphs 8 through 23. Respondent's consistent and repeated multiple failures to communicate his rationale and information supportive of his assessments, as alleged in paragraphs 8 through 23, represent an extreme departure from the standard of care.

26. Respondent departed from the standard of care by failing to construe and/or document reasonable treatment plans consistent with Patient A's presentation or deemed assessment as alleged in paragraphs 8 through 23. Respondent's consistent and repeated multiple failures to construe and/or document reasonable treatment plans, as alleged in paragraphs 8 through 23, represent an extreme departure from the standard of care.

///

///

///

[7] Gastroesophageal Reflux Disease.

## SECOND CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

27. Respondent Lawrence Delano Tran, M.D. is subject to disciplinary action under section 2234, subdivision (c) in that he committed repeated negligent acts in the care and treatment of one patient. The circumstances are as follows:

28. Allegations of paragraphs 8 through 23 are incorporated herein by reference.

29. Respondent departed from the standard of care by failing to obtain and document appropriate history and physical examination of Patient A. Each of Respondent's failures to obtain and/or record the patient's history and physical examination, as alleged in paragraphs 8 through 23, represents a separate departure from the standard of care.

30. Respondent departed from the standard of care by failing to communicate his rationale and information supportive of his assessments of Patient A. Each of Respondent's failures to communicate his rationale and information supportive of his assessments, as alleged in paragraphs 8 through 23, represents a departure from the standard of care.

31. Respondent departed from the standard of care by failing to construe and/or document reasonable treatment plans consistent with Patient A's presentation or deemed assessment. Each of Respondent's failures to construe and/or document reasonable treatment plans, as alleged in paragraphs 8 through 23, represents a departure from the standard of care.

32. Respondent's failure to document an addendum on progress notes that contained errors or conflicting information, as alleged in paragraphs 8 through 23 herein, constitutes a departure from the standard of care.

33. Respondent's prescribing of Vicodin to Patient A in the manner alleged in paragraph 14 herein constitutes a departure from the standard of care.

///

///

///

///

///

## THIRD CAUSE FOR DISCIPLINE

**(Inadequate Record Keeping)**

34. Respondent Lawrence Delano Tran, M.D. is subject to disciplinary action under section 2266 in that he failed to maintain adequate and/or accurate medical records of his treatment of Patient A. The circumstances are as follows:

35. Allegations of paragraphs 8 through 23 are incorporated herein by reference.

## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 34193 issued to Lawrence Delano Tran, M.D.;

2. Revoking, suspending or denying approval of Lawrence Delano Tran, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Lawrence Delano Tran, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: April 30, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

LA2018600499
62748820.doc